STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner

In the matter of the End Stage Renal
Disease Provider Class Plan Determination
Report pursuant to Public Act 350 of 1980
_____/

No. 11-046-BC

Issued and entered
this 5th day of December 2011
by R. Kevin Clinton
Commissioner

ORDER ISSUING DETERMINATION REPORT

I

BACKGROUND

Pursuant to Public Act 350 of 1980, as amended (Act), being MCLA 550.1101 et seq.; MSA 24.660 (101) et seq., the Commissioner of the Office of Financial and Insurance Regulation (Commissioner) issued Order No. 11-030-BC on July 12, 2011, giving notice to Blue Cross and Blue Shield of Michigan (BCBSM), and to each person who requested a copy of such notice, of his intent to make a determination with respect to the end stage renal disease provider class plan for calendar years 2009 and 2010.

II

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Based upon the foregoing considerations it is FOUND and CONCLUDED that:

1. Jurisdiction and authority over this matter are vested in the Commissioner pursuant to the Act.

2. BCBSM has complied with all applicable provisions of the Act.

3. All procedural requirements of the Act have been met.

4. The staff reviewed relevant data pertaining to the end stage renal disease provider class plan as discussed in the attached report, including written comments received

during the input period on the provider class plan. The input period was designed to provide the public with an opportunity to present data, views, and arguments with respect to the end stage renal disease provider class plan.

5. Pursuant to Section 510(2) of the Act, a copy of the determination report and this order shall be sent to the health care corporation and each person who has requested a copy of such determination by certified or registered mail.

III

ORDER

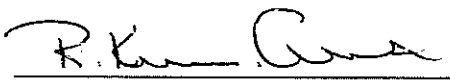
Therefore, it is ORDERED that:

1. The attached end stage renal disease provider class plan determination report shall be incorporated by reference as part of this order and shall serve as the Commissioner's determination with respect to the end stage renal disease provider class plan for the calendar years 2009 and 2010.

2. Pursuant to Section 510(2) of the Act, the Commissioner shall notify BCBSM and each person who has requested a copy of such determination by certified or registered mail.

3. Pursuant to Section 515(1) and (2), any appeal must be filed within 30 days of the date of this determination report. The request for an appeal shall identify the issue or issues involved and how the person is aggrieved.

The Commissioner retains jurisdiction of the matters contained herein and the authority to enter such further order or orders as he shall deem just, necessary and appropriate.



R. Kevin Clinton
Commissioner

RICK SYNDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
R. KEVIN CLINTON, COMMISSIONER

STEVEN H. HILFINGER
DIRECTOR

Blue Cross and Blue Shield of Michigan's End Stage Renal Disease Provider Class Plan for calendar years 2009 and 2010

A Determination Report issued by Commissioner R. Kevin Clinton

December 2011

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END STAGE RENAL DISEASE

PROVIDER CLASS PLAN

DETERMINATION REPORT

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EXECUTIVE SUMMARY

Pursuant to Public Act 350 of 1980, this report provides a review and determination of whether the arrangements Blue Cross and Blue Shield of Michigan (BCBSM) has established with health care providers have substantially achieved the access, quality of care, and cost goals set forth in the Nonprofit Health Care Corporation Reform Act for calendar years 2009 and 2010. The statutory goals specify that these arrangements, known as provider class plans, must assure subscribers reasonable access to, and reasonable cost and quality of, health care services covered under BCBSM's certificates.

The analysis and determination of goal performance is based on BCBSM's 2009-2010 end stage renal disease provider class plan annual report, additional data requested of BCBSM, and information on file with respect to this provider class plan. This material was supplemented as necessary by data from published sources. The determination report analyzes the level of achievement for each goal separately and discusses interaction and balance among the goals.

Access Goal

Achievement of the access goal requires BCBSM to be able to assure that, in any given area of the state, a BCBSM member has reasonable access to end stage renal disease services whenever necessary. In analyzing BCBSM's performance on the access goal, consideration was given to the formal participation rates of end stage renal disease providers. The number of end stage renal disease providers participating with BCBSM in most Michigan regions is at an acceptable level. The lack of complaints on file with OFIR regarding the inability of BCBSM members to access freestanding end stage renal disease facilities in the western Upper Peninsula region seems to illustrate members are able to obtain end stage renal disease services in outpatient hospital settings or in Wisconsin. BCBSM also demonstrated a commitment to service through the availability of easily accessible electronic publications and tools and effective provider servicing. Based on these facts, it is determined that BCBSM met the access goal during 2009 and 2010.

Quality of Care Goal

The quality of care goal requires BCBSM to assure that providers meet and abide by reasonable standards of health care quality. To achieve this goal, BCBSM must show that it makes providers aware of practice guidelines and protocols for end stage renal disease services, that it verifies that providers adhere to such guidelines and that it maintains effective methods of communication with its providers. During calendar years 2009 and 2010, BCBSM continued to ensure that its qualification standards for participation were met by end stage renal disease providers. BCBSM also conducted utilization review audits to ensure that the services rendered to BCBSM patients were medically necessary and appropriately administered, and had an established appeal process to deal with provider disputes. BCBSM offered a number of member-focused initiatives, including online tools, health assessments and magazines as well as the BlueHealthConnection® program to assist members in managing their own health. BCBSM acknowledged that one of its "standardized" objectives listed in all provider class plans to meet with the appropriate

specialty liaison society is not commonly practiced with end stage renal disease providers. BCBSM stated it will rewrite this particular objective in the end stage renal disease provider class plan to reflect its current practices to communicate with end stage renal disease providers about issues of interest and concern. It is therefore determined that BCBSM met the statutory goal for calendar years 2009 and 2010.

Cost Goal

The cost goal requires that the arrangements BCBSM maintains with each provider class will assure a rate of change in the total corporation payment per member that is not higher than the compound rate of inflation and real economic growth. Achievement of the cost goal is measured by application of the cost formula specified in the Act, which is estimated to be 0.6% for the period under review. As the rate of change in the total corporation payment per member for the end stage renal disease provider class has been calculated to be a increase of 0.6% over the two years being reviewed, BCBSM met the cost goal stated in the Act for 2009 and 2010.

Overall Balance of Goals

In summary, BCBSM met all three statutory goals for the end stage renal disease provider class for the two-year period under review.

Introduction

The purpose of this report is to determine whether Blue Cross and Blue Shield of Michigan (BCBSM) met the access, quality of care, and cost goals outlined in the Nonprofit Health Care Corporation Reform Act, MCLA 550.1101 et seq. (Act), with respect to the end stage renal disease provider class plan for the calendar years 2009 and 2010.

In addition to the final determination, this report will: define a provider class plan, explain the statutory review process, and provide a detailed summary of the data considered in reaching the determination as well as a statement of findings, which support that determination.

Provider Class Plans - Legal Background

Section 107(7) of the Act, defines a provider class plan as "a document containing a reimbursement arrangement and objectives for a provider class, and, in the case of those providers with which a health care corporation contracts, provisions that are included in that contract." Simply stated, a provider class plan is a document that includes measurable objectives for meeting the nonprofit health care corporation's access, quality of care, and cost goals outlined in the Act.

Section 504(1) of the Act requires BCBSM to contract with or enter into a reimbursement arrangement with providers in order to assure subscribers reasonable access to, and reasonable cost and quality of, health care services in accordance with the following goals:

1. BCBSM must contract with or enter into reimbursement arrangements with an appropriate number of providers throughout the state to assure the availability of certificate covered health care services to each subscriber. Section 502(1) of the Act specifically indicates that a participating contract with providers includes not only agreements in which the providers agree to participate with BCBSM for all BCBSM members being rendered care, but also agreements in which the provider agrees to participate only on a per-case basis. Participation with BCBSM means that a provider of health care services agrees to accept BCBSM's approved payment as payment in full for services provided to a BCBSM member.

2. BCBSM must establish and providers must meet and abide by reasonable standards of quality for health care services provided to members.

3. BCBSM must compensate providers in accordance with reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth.

Section 509(4) of the Act requires the Commissioner of Financial and Insurance Regulation (Commissioner) to consider various types of information in making a determination with respect to the statutory goals. This information includes:

1. Annual reports filed by BCBSM, which pertain to each respective provider class;

2. Comments received from subscribers, providers, and provider organizations;

3. Health care legislation;

4. Demographic, epidemiological and economic trends;

5. Administrative agency or judicial actions; sudden changes in circumstances; and changes in health care benefits, practices and technology.

The Commissioner shall also assure an overall balance of the goals so that one goal is not focused on independently of the other statutory goals and so that no portion of BCBSM's fair share of reasonable costs to the provider are borne by other health care purchasers. After careful consideration of all of the information that was submitted or obtained for the record, the Commissioner must make one of the following determinations pursuant to Section 510(1) of the Act:

(a) That the provider class plan achieves the goals of the corporation as provided in Section 504 of the Act.

(b) That although the provider class plan does not substantially achieve one or more of the goals of the corporation, a change in the provider class plan is not required because there has been competent, material, and substantial information obtained and submitted to support a determination that the failure to achieve one or more of the goals was reasonable due to the factors listed in Section 509(4) of the Act.

(c) That the provider class plan does not substantially achieve one or more of the goals of the corporation as provided in Section 504 of the Act.

If the Commissioner determines that the plan does not substantially achieve one or more of the goals, without a finding that such failure was reasonable, BCBSM must transmit to the Commissioner within six months a provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings. If after six months or such additional time as provided for in Section 512, BCBSM has failed to submit a revised provider class plan as stated above, the Commissioner must then prepare a provider class plan for that provider class.

Overview of the End Stage Renal Disease Provider Class Plan

End stage renal disease is the complete, or nearly complete, failure of the kidneys to function. The main function of the kidneys is to remove wastes and excess water from the body. According to the American Kidney Foundation, end stage renal disease usually occurs when chronic kidney disease has worsened to the point at which kidney function is less than 10% of normal. A person may have gradual worsening of kidney function for 10-20 years or more before progressing to end stage renal disease. Patients who reach this stage need dialysis or a kidney transplant.

The end stage renal disease (ESRD) provider class for BCBSM is designed to provide benefits for the treatment of chronic renal failure and includes dialysis services in the ESRD facility or in the home. BCBSM reimburses ESRD services when such services were provided in accordance with member certificates. Services available at ESRD facilities include, but are not limited to, the following:

- Use of freestanding end-stage renal disease facility and equipment
- Routine laboratory tests
- Medical and other supplies
- Solutions and drugs
- Ultra-filtration
- Self-dialysis training

BCBSM states that ESRD patients have a three-month waiting period and a 30 month coordination period during which BCBSM is primary before patients are eligible for Medicare coverage. Once the coordination period ends, BCBSM becomes the secondary payer.

If a BCBSM member with ESRD has a kidney transplant, Medicare remains primary for 36 months. Transplants are considered to be successful if the member has not rejected the kidney within that time period. At that point, the member is no longer considered to have ESRD and the Medicare coverage ends. If a BCBSM member has a kidney transplant that is not successful, that member continues to be eligible for Medicare.

For the period 2009-2010, payments to end stage renal disease providers represented an average of 0.5% of the total benefit payments made to health care providers on behalf of BCBSM members. For the purpose of provider class plan reviews by the Office of Financial and Insurance Regulation (OFIR), paid claims data are categorized by nine geographic regions. A map, which depicts these geographic regions, is included in Attachment A.

End stage renal disease providers are subject to certain qualification standards set by BCBSM. BCBSM's end stage renal disease provider class plan indicates providers must:

- Maintain current Medicare certification as a renal dialysis facility and be certified for each maintenance station it operates and each service it provides;

- Have a physician director who is designated, in writing, to assume overall responsibility for coordinating patient care;

- Have written policies and procedures that meet generally acceptable standards as determined by BCBSM for outpatient end-stage renal disease services to assure the quality of patient care, and demonstrate compliance with such policies and procedures;

- Have a governing board that is legally responsible for the total operation of the facility and for ensuring that quality medical care is provided. The governing board, or as an alternative, a community advisory board responsible to the governing board, must include persons representative of a cross-section of the community who are interested in the welfare and proper functioning of the end-stage renal facility as a community agency;

- Comply with Certificate of Need requirements of the Michigan Public Health Code, as applicable;

- Document that BCBSM's Evidence of Necessity requirements are met;

- Absence of inappropriate utilization or practices as identified through valid subscriber complaints, audits, and peer review;

- Conduct financial affairs of the facility in a manner consistent with prudent fiscal management. Maintain records of transactions in conformity with generally accepted accounting principles and BCBSM billing, reporting and reimbursement policies and procedures.

Reimbursement for covered end stage renal disease services is made only for covered services rendered by BCBSM participating facilities. ESRD facility reimbursement is limited to the lesser of the facility's billed charge or BCBSM's maximum payment level based on the type of service provided less any deductible or copayment that is the member's responsibility. BCBSM states that reimbursement for hemodialysis services is the same for both in-facility and services received at home. The maximum payment rate for ESRD facility services is listed on BCBSM's ESRD Facility Rate Schedule found in BCBSM's Web-DENIS provider information. Each dialysis service is priced at an all-inclusive rate that includes cost of the treatment, labor, overhead, equipment, supplies, solutions, drugs, laboratory work and all other medically necessary services related to the dialysis service. All inclusive rates are reviewed by BCBSM and updated annually by the National Hospital Input Price Index (NHIPI) as published by Global Insights in August for the following calendar year. BCBSM does not guarantee the annual updates will result in increased reimbursement.

During the review period, end stage renal disease providers could participate with BCBSM only under its formal participation program. A formally participating provider has signed an agreement to accept BCBSM reimbursement as payment in full, excluding applicable co-payments or deductibles, for all covered services rendered to BCBSM members by the provider.

BCBSM is required to include as part of each provider class plan its objectives toward achieving the goals specified in the Act. BCBSM's objectives with regard to the end stage renal disease provider class plan are to:

Access:

- Provide direct reimbursement to participating providers who render medically necessary, high-quality services to BCBSM members.
- Communicate with participating providers about coverage determinations, billing, benefits, provider appeals processes, BCBSM's record keeping requirements and the participating agreement and its administration.
- Maintain and periodically update a printed or web site directory of participating providers.

Quality of Care:

- Ensure BCBSM members receive quality care by requiring participating providers to meet BCBSM's qualification and performance standards.
- Meet with specialty liaison societies to discuss issues of interest and concern.
- Maintain and update, as necessary, an appeals process that allows participating providers to appeal individual claims disputes regarding utilization review audits.

Cost:

- Strive toward meeting the cost goal within the confines of Michigan and national health care market conditions.
- Provide equitable reimbursement to participating providers through the reimbursement methodology outlined in the participation agreement

History of the End Stage Renal Disease Provider Class Plan

BCBSM first filed the end stage renal disease provider class plan with OFIR pursuant to Section 506(1) of the Act on June 24, 1988.

Section 506(2) states:

> "Upon receipt of a provider class plan, the commissioner shall examine the plan and shall determine only if the plan contains a reimbursement arrangement and

> objectives for each goal provided in Section 504, and, for those providers with which a health care corporation contracts, provisions that are included in that contract."

Section 506(2) further states:

> "For purposes of making the determination required by this subsection only, the commissioner shall liberally construe the items contained in a provider class plan."

Since the end stage renal disease provider class plan met the filing requirements of Section 506 of the Act stated above, OFIR retained the end stage renal disease provider class plan on July 11, 1988 and it was placed into effect pursuant to Section 506(4).

On February 6, 1995, BCBSM amended its provider class plans to reflect BCBSM's participation in the Inter-plan Teleprocessing System (ITS) and the disclosure requirements of the Blue Cross Blue Shield Association.

On June 24, 1996, BCBSM amended all of its non-hospital, non-physician provider class plans, including the end stage renal disease plan, to include an appeal process for utilization review audits performed by the corporation. This amendment to the end stage renal disease provider class plan was made by BCBSM in accordance with Section 508(1) of the Act.

The end stage renal disease provider class plan was also modified by BCBSM on December 26, 1997, April 27, 2000 and February 14, 2007. In 1997, BCBSM modified its appeal process for its non-hospital, non-physician provider classes. In May 2002, BCBSM updated its provider participation agreement. In February 2007, BCBSM filed a modified provider class plan revising its reimbursement methodology in order to be able to reimburse end stage renal disease facilities all-inclusive rates for dialysis treatment based on the type of service. This revised methodology eliminated billing for other services considered medically necessary and directly related to dialysis treatment.

Review Process

On July 12, 2011, the Commissioner issued Order No. 11-030-BC, which provided written notice to BCBSM, health care providers, and other interested parties of his intent to make a determination with respect to the end stage renal disease provider class plan for calendar years 2009 and 2010. Order No. 11-030-BC also called for any person with comments on matters concerning the provider class plan to submit such comments to OFIR in accordance with Section 505(2) of the Act. Section 505(2) requires the Commissioner to establish and implement procedures whereby any person may offer advice and consultation on the development, modification, implementation, or review of a provider class plan. Requests for written testimony on BCBSM's end stage renal disease provider class plan were sent to all those on OFIR's interested persons list for the end stage renal disease provider class and posted on OFIR's website, providing interested parties two months to prepare and submit testimony.

Summary of Written Input:

Requests for written testimony regarding the end stage renal disease provider class plan were sent to those on OFIR's interested persons list, the Michigan Urological Society and posted on OFIR's website. No testimony was received during the two year period under review in regard to BCBSM's end stage renal disease provider class plan.

Discussion of Goals Achievement/Findings and Conclusions

Access Goal:

The access goal in Section 504(1) of the Act states that "[T]here will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber."

In order to achieve compliance with the access goal, BCBSM needs to be able to assure, that in any given area of the state, a BCBSM member has reasonable access to end stage renal disease services covered under the terms of that member's certificate whenever such treatment is required. In analyzing BCBSM's performance on the access goal, OFIR staff examined several aspects of how access to end stage renal disease services could be obtained, including the formal participation rates of providers, to get an overall picture of how well BCBSM was assuring the availability of certificate-covered health care services to each member throughout the state.

BCBSM acknowledged during the course of this review that its description of how participation rates are calculated in its end stage renal disease annual report is incorrect. BCBSM states that it obtains the number of licensed end stage renal disease facilities by making a freedom of information request to the state of Michigan. BCBSM has indicated that its annual report should state that BCBSM's formal participation rates are derived by comparing the total number of formally participating providers to the number of freestanding licensed providers. The following information, supplied by BCBSM in December 2010, shows the number of Michigan licensed and participating end stage renal disease providers and membership by geographic region for calendar years 2008 through 2010:

End Stage Renal Disease Provider Class Plan
Formal Participation Rates

Formal Participation Rates	2008	2009	2010
Formally Participating	133	145	146
All Licensed Providers	138	147	150
Formal Participation Rates	96.4%	98.6%	97.3%

In order to assess how the participation rates of end stage renal disease providers affect BCBSM member access to care, BCBSM provided the location of participating and registered providers by county for 2009. Review of the end stage renal disease providers on a regional basis reveals that the majority of BCBSM's participating providers are located in southeastern Michigan. The remaining regions appear to have adequate access to an end stage renal disease provider, with the exception of the western portion of the Upper Peninsula. BCBSM states that its claims experience showed members close to the Wisconsin border received treatment in Wisconsin. The lack of cost data for the Upper Peninsula region, noted in the cost goal section of this determination report, reveals that BCBSM members typically received outpatient hospital treatment in that region or obtained end stage renal disease services in Wisconsin.

BCBSM's communication efforts also impact access to care as it helps establish and maintain a good rapport with participating providers.

BCBSM distributes to all providers a publication called the *Record.* This monthly publication contains current information relating to billing, reimbursement, group-specific benefit changes, day-to-day business information and medical criteria modifications. The *Record* was created with input from provider focus groups as an ongoing effort to improve communications with providers and to make BCBSM information more accessible to them.

As part of the review process, OFIR examined a copy of BCBSM's end stage renal disease provider manual obtained from BCBSM's Web-DENIS. The provider manual is continuously updated online, includes information, such as participation requirements, patient eligibility requirements, admission verification and pre-certification, benefits and exclusions, criteria and guidelines for services, documentation guidelines, claim submission information, and sections describing audit information, claims appeals processes, utilization review, and how to obtain information from BCBSM's provider inquiry department.

BCBSM states it offers providers the options of speaking with provider service representatives, writing to its inquiry department and having a provider consultant visit provider offices to help guide and educate their staff. BCBSM trainers also educate providers with seminars on various topics such as how to use web-DENIS, benefits, claims processing and adjustments. Computer based training tools have also been developed to expand the reach of the training sessions.

BCBSM's web-DENIS system offers BCBSM providers an internet-based program via a secured provider portal on www.bcbsm.com. This program provides quick delivery of contract eligibility, claims status, online manuals, newsletters, fee schedules, medical and benefit policy information for any procedure or revenue code, reports and other types of required information designed to make doing business with BCBSM easier. BCBSM designed the Internet site to promote secure, effective and personalized use of the Internet for existing web-DENIS users and to encourage new providers to begin to use web-DENIS.

BCBSM states it continues to enhance web-DENIS capabilities. In 2008, BCBSM introduced a new search tool, Explainer, to web-DENIS. Explainer offers more information than the previous search tool and includes medical, benefit and payment policy information. Payment policy information provides member cost-sharing and dollar maximums with detail available at the procedure and revenue code levels for selected time periods. Also during 2008, BCBSM simplified web-DENIS by standardizing the look of the screens for members' claims processed on the local and NASCO claims systems. In 2009, web-DENIS added new claims tracking and screen printing capabilities and information on members' other active coverage.

Another avenue for end stage renal disease providers to obtain needed information from BCBSM is CAREN^{+}, an integrated voice response system which provides information on eligibility, benefits, deductibles and co-payments. CAREN^{+} will transfer the caller directly to a service representative if they say "representative". Several enhancements were made to CAREN^{+} to speed up inquiries and improve privacy. For example, protected health information can be keyed in using the telephone keypad to prevent other patients from overhearing information verbally told to CAREN^{+}. The system repeats the information back to the caller to verify accuracy.

BCBSM has also instituted several provider affiliation strategy programs to foster an ongoing commitment to excellent performance and dialogue with providers. BCBSM states it promotes business relationships with providers so they will: 1) collaborate with BCBSM to improve the health status of patients and the quality and cost effectiveness of care; 2) help BCBSM deliver outstanding customer service to members; and 3) value BCBSM as a health plan of choice and recommend it to patients and others. The provider affiliation strategy focuses on increasing provider satisfaction and creating a strong relationship with providers by providing a prompt and accurate claims payment system, consistent, accurate and responsive service; timely and effective communication, and partnerships to promote and facilitate better health care.

The Blue Cross Blue Shield of Association Member Touchpoint Measures (MTM) Program assesses operational and service performance of all BCBS Plans by measuring on a quarterly basis: the accuracy of the subscriber-level enrollment process so that claims and bills are processed correctly; that customer service representatives answer inquiries promptly and correctly; customers and providers receive correct benefit and eligibility information; and the subscriber has access to all benefits and network providers. The MTM Program is calculated across all provider classes. BCBSM's MTM scores have progressed steadily over the past few years when compared to the 55 other Blue plans. Since 2008, BCBSM climbed from 25th to 12th and achieved first place among all plans for the quarter ending March 31, 2009 by scoring 100% on all measures.

In 2010, the Blue Cross Blue Shield Association added two new MTM metrics to the program: First Call Resolution and Blue Experience Metric. First Call Resolution tracks a plan's ability to resolve a customer's issue with just one call. Blue Experience Metric captures the "voice of the customer". In particular, it focuses on a customer's experience

related to wellness programs, customer service, claims payment, provider/network access and member education.

In addition to the MTMs, BCBSM also started a new PGIP initiative in 2010 related to chronic kidney disease. The goal of the project is to develop a registry of comprehensive clinical and demographic patient information that can be used to effectively manage a population of patients who have or could potentially develop chronic kidney disease.

BCBSM states that effective July 2009, both BCBSM traditional and PPO providers funded the PGIP initiative. The chronic kidney disease PGIP initiative will impact ESRD providers as the initiative's purpose is to improve identification and management of individuals with kidney disease and create a team-based approach to project disease progression and improve quality of care and outcomes for kidney disease patients.

BCBSM states that ESRD services are also available to members in the outpatient hospital setting. Services performed in a hospital outpatient setting are included as part of the hospital provider class plan. The majority of freestanding ESRD facilities are owned by large firms that have resources to advance treatment and maintain current equipment necessary to maximize the quality of patient care.

Only those members diagnosed with chronic end stage renal disease are eligible to receive ESRD benefits under this particular provider class plan. Once the waiting period and coordination of benefits period expire, members may receive services covered under Medicare, with BCBSM as the secondary payer.

Findings and Conclusions - Access

In order to achieve compliance with the access goal, BCBSM needs to be able to assure that in any given area of the state a member has reasonable access to certificate-covered end stage renal disease services, whenever such services are required. The number of end stage renal disease providers participating with BCBSM in most Michigan regions is at an acceptable level. The lack of complaints on file with OFIR regarding the inability of BCBSM members to access end stage renal disease in the western Upper Peninsula region seems to illustrate members are able to obtain end stage renal disease services in outpatient hospital settings or in Wisconsin. As such, it is determined that BCBSM generally met the access goal stated in the Act for calendar years 2009 and 2010.

Quality of Care Goal:

The quality of care goal in Section 504(1) of the Act states that "[P]roviders will meet and abide by reasonable standards of health care quality."

In analyzing BCBSM's performance on the quality of care goal, OFIR staff examined BCBSM's achievement of its quality of care objective, the methods BCBSM utilized in establishing and maintaining appropriate standards of health care quality, and BCBSM's

methods of communication with end stage renal disease providers. We reviewed these factors to assure that BCBSM not only encouraged provider compliance with the expected standards of end stage renal disease services, but also that it kept abreast of new technological advances available to treat those BCBSM members that require such services. All of the above factors impact the quality of end stage renal disease services delivered to BCBSM members. The pertinent issues that were considered in reaching a determination with respect to the quality of care goal, based on the review of data provided by BCBSM and other sources during this review period, are described below.

BCBSM states the following factors impacted quality of care performance:

- BCBSM enforced accreditation requirements and qualification standards through the provider credentialing process. Providers who could not demonstrate compliance with BCBSM requirements were not allowed to participate.

- An appeals process is outlined and communicated to providers in the provider manual. The process outlined the steps a provider may follow to dispute claims and audit decisions. BCBSM states that during the two year period under review, there were no new requests for a review and determination by OFIR.

- Quality controls were used to ensure that providers maintained high standards of care. In addition, BCBSM was involved in many programs to improve the quality of care to its members and Michigan residents.

To ensure acceptable levels of care provided by end stage renal disease providers, BCBSM requires that these providers meet the participation qualifications and performance standards listed on pages three and four of this report. BCBSM states it enforced accreditation requirements and qualification standards through the provider credentialing process. Providers who could not demonstrate compliance with BCBSM's requirements were not allowed to participate with BCBSM.

BCBSM also monitors provider performance through its utilization review process. Audits can determine if services were medically necessary and rendered in accordance with members' benefits. Audit findings during the two year period under review included overpayments and services billed but not documented in the medical record.

During utilization review audits, paid claims data and the corresponding medical records are reviewed to ensure that end stage renal disease services were appropriate and the services rendered were performed for the appropriate indications, in appropriate settings and were accurately billed and paid. At the conclusion of the audit, a departure conference with the facility representative, led by a BCBSM auditor, provides preliminary findings identified in the audit. The departure conference also serves as an opportunity for education. Methods to enhance correct coding and billing practices are discussed and facilities are encouraged to build on existing strengths.

As illustrated below, BCBSM conducted 246 audits of end stage renal disease providers during the two year period under review.

End Stage Renal Disease Facilities Audit Results		
	2009	2010
Number of audits	127	119
Initial Identified Savings	$830,594	$580,075
Collected Savings	$580,662	$375,451
Pending Recoveries	$536	$150,038
Referred to CFI*	0	0

*Corporate Financial Investigations

It was noted that BCBSM audited a much larger percentage of ESRD providers in comparison to the actual number of ESRD providers. For example, based on information available to OFIR, in 2008, BCBSM audited just 142 of 23,742 medical doctors and doctors of osteopathy, yet in 2009, BCBSM audited 127 of 137 ESRD providers. BCBSM states that it audits nearly 100% of ESRD providers due to billing errors identified during the last several years. The audits are automated and they are performed to ensure ESRD providers are in compliance with BCBSM's billing guidelines.

Another measure of BCBSM's achievement of the quality of care goal includes BCBSM's ability to effectively communicate with providers. Given that the quality of care goal defined in the Act requires that "providers meet and abide by reasonable standards of health care quality," it is necessary for providers to be made aware of BCBSM's standards, for BCBSM to verify that its providers adhere to such standards and that BCBSM is responsive to provider inquiries, input, and appeals, as all of these factors impact the quality of end stage renal disease services given to BCBSM members.

One of BCBSM's objectives for the end stage renal disease provider class plan is to meet with specialty liaison societies to discuss issues of interest and concern. BCBSM notes its liaison process has changed considerably over the last several years due to changes in its corporate organization. BCBSM did not meet directly with any end stage renal disease providers but states it is open to having dialogue or liaison meetings with specialty societies or organizations to obtain provider input on issues of interest and concern. BCBSM states that questions about the end stage renal disease benefit, billing issues or other concerns can be directed to BCBSM's provider consultants. BCBSM states that for future reporting, BCBSM will rewrite this objective to better reflect its communication with end stage renal disease providers.

BCBSM states that it maintains open communications with end stage renal disease providers through its monthly publications, provider manuals, and its formal appeal process. All participating end stage renal disease providers receive BCBSM's monthly publication of the *Record*. BCBSM states the issues discussed in this publication are those that often impact providers' practice patterns and the achievement of utilization

performance standards. BCBSM also has regional field services representatives that are available for on-site, individualized provider education and to address problems and concerns. Providers also receive direct mailings from BCBSM announcing changes in benefit programs and requesting provider feedback on these types of issues.

BCBSM states it offers facility seminars for new billers or office staff. The primary objective is to help billers gain working knowledge of hospital and freestanding facility billing. Web-DENIS training is also provided by a provider consultant on an individual basis. BCBSM states it offered ESRD providers the opportunity for training in October 2010. This particular training was specifically related to ESRD facilities. It was a seminar designed for new billers who were using the UB-04 claim form to report services. The primary objective was to help billers gain working knowledge of facility billing. BCBSM states that although it published this class in its provider training class schedule, BCBSM didn't have anyone from an ESRD facility register for this class so it the training seminar was cancelled.

BCBSM also maintains a provider appeal process for end stage renal disease providers. The purpose of the appeal process is to resolve claim or audit disagreements. The appeal process is periodically published in the *Record* and is outlined in detail in both the online provider manual and the end stage renal disease facility participating agreement.

There are many different levels of the appeals process. The provider starts with a routine inquiry to BCBSM and can follow with a written complaint asking for a reconsideration review. If the provider is not satisfied with the reconsideration, the facility may submit a written request for a Managerial-Level Review Conference. During this conference, BCBSM and the provider discuss the dispute in an informal setting and explore possible resolutions of the dispute.

If the provider is dissatisfied with the managerial-level review, the provider can continue with BCBSM's appeal process, appeal to OFIR, initiate legal action, or if medical necessity issues are in dispute, request an external peer review for medical necessity issues. If the external review is decided in favor of BCBSM, the provider will pay the costs of the peer review. If the review is decided in favor of the provider, BCBSM pays the costs. If the findings are partially upheld and partially reversed, BCBSM and the provider share the costs of peer review in proportion to the results as measured by the findings upheld or reversed. The decision of the external review organization on medical necessity disputes is final and binding on both the provider and BCBSM.

For disputes involving administrative, billing and coding disputes, a provider may request a review by an internal review committee. BCBSM's Internal Review Committee is composed of three members of BCBSM senior management. If providers are unhappy with the Internal Review Committee decision, they can appeal to BCBSM's Provider Relations Committee. The Provider Relations Committee is a subcommittee of the BCBSM Board of Directors composed of BCBSM participating professionals, community leaders and BCBSM senior management.

Providers that go through BCBSM's appeals process and remain dissatisfied can appeal medical necessity issues and administrative and billing and coding issues to OFIR for an informal review and determination. If the provider remains dissatisfied, they can move to a contested case hearing pursuant to Section 550.1404(6) of the Act. Contested case hearing decisions are subject to appeal in the circuit court.

BCBSM states there were no end stage renal disease audit appeals to OFIR during the two-year period under review.

BCBSM states that people with chronic kidney disease are at increased risk for cardiovascular disease and are more likely to die from cardiovascular disease than progress to end stage renal disease. According to the American Kidney Foundation, the most common causes of ESRD in the United State are diabetes and high blood pressure. BCBSM states it provides members with materials to assist them in making health care decisions including decisions related to high blood pressure and diabetes.

BCBSM quality initiatives include educational materials sent directly to members as well as online tools. Magazines such as *Lifestyles for Health Living* and *Living Healthy* are sent to members seasonally. These magazines are meant to complement the advice of health care professionals as well as to assist members in learning how to manage their own health. In addition, the Succeed™ Health Assessment and online coaching programs are available at bcbsm.com.

In the Winter 2010 edition of *Healthy Living,* BCBSM explains the online health assessment and the recommended online coaching programs that are available to members who need help with their health challenges. After completion of the health assessment, a program called Care™ for Diabetes is available for those members with diabetes. Care™ for Diabetes is one of several online coaching programs and it offers a personalized plan for managing diabetes. This coaching program is also available as a free app for the iPhone® and IPod®. The Step by Step™ mobile app allows members to track physical activity and health statistics while reinforcing healthy, positive behavior.

BlueHealthConnection® is a confidential program that gives members the information, tools and assistance they need to manage a chronic condition such as diabetes, heart failure, coronary artery disease, chronic obstructive pulmonary disease and asthma.

Eligible members who choose to participate in this voluntary program receive one-on-one support from a registered nurse case manager, who helps the member better understand and manage his/her condition. Over the course of a few months, the nurse case manager works with the member to set goals and implement a plan to manage a chronic condition.

The plan may suggest one of the online coaching programs available to help members address their key health challenges, such as:

- Breathe™ - smoking cessation program
- Care™ for your Health, a chronic illness self-management program
- Care™ for Diabetes
- Balance™, a weight management and physical activity program
- Nourish™, a nutritional management program
- Care™ for Your Back, a low back pain treatment program
- Relax™ - stress management program
- Care™ for Your Pain – a pain management program
- Overcoming™ Depression – a cognitive behavioral therapy – based self-management program
- Overcoming™ - Insomnia – a program to help people get the sleep they need to be productive at work and effective in their lives
- Overcoming™ Binge Eating – a cognitive behavioral therapy-based self-management obesity program

Other online tools are also available to help members take charge of their health, including fitness videos that can be downloaded to an MP3 player, calculators, podcasts, healthy recipes and quizzes.

Findings and Conclusions - Quality of Care

In order to meet the quality of care goal, the provider class plan must assure that "providers will meet and abide by reasonable standards of health care quality." During calendar years 2009 and 2010, BCBSM required all end stage renal disease providers to meet its qualification standards for participation and maintained communication with these providers through its monthly publications, appeal processes, provider manuals, online resources and member focused quality initiatives. BCBSM acknowledged that one of its "standardized" objectives listed in most all provider class plans to meet with specialty liaison societies is not commonly practiced with end stage renal disease providers. BCBSM stated it will rewrite this particular objective to reflect is current business practice to communicate with end stage renal disease providers about issues of interest and concern. As such, based on the information analyzed during this review, it is determined that BCBSM met the quality of care goal stated in the Act for calendar years 2009 and 2010.

Cost Goal:

The cost goal in Section 504(1) of the Act states that "[P]roviders will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth."

After application of the cost formula found in Section 504 of the Act and using economic statistics published by the U. S. Department of Commerce, it is hereby determined that the measure that will be used to determine BCBSM's achievement of the cost goal shall be as follows:

> The rate of change in the total corporation payment per member for the end stage renal disease provider class for calendar years 2009 and 2010 shall not exceed 0.6%.

The pertinent issues that were considered in reaching a determination with respect to the cost goal are described below.

The cost goal formula, as stated in the Act, is

$$\frac{[(100 + I) \times (100 + REG)]}{100} - 100 = \text{Compound rate of inflation and real economic growth}$$

"I" is "inflation" which is the arithmetic average of the percentage change in the implicit price deflator for GNP over the two calendar years immediately preceding the year in which the Commissioner's determination is being made.

"REG" is "real economic growth" which is the arithmetic average of the percentage change in per capita Gross National Product (GNP) in constant dollars over the four calendar years immediately preceding the year in which the Commissioner's determination is being made.

Given the December 2009 population data obtained from monthly population estimates published by the Bureau of Census, as obtained from the U. S. Census Bureau and economic statistics for the GNP and implicit GNP price deflator from the U. S. Department of Commerce, Bureau of Economic Analysis as published in April 2011 by the Federal Research Bank of St. Louis (research.stlouisfed.org/fred2/data/GNPC96.txt and research.stlouisfed.org/fred2/data/ GNPDEF.txt), the following calculations have been derived:

I = Inflation as defined in the cost goal formula:

	% change in implicit GNP price deflator
2009	0.4
2010	1.4
2 yr. average	0.9

REG = Real Economic Growth as defined in the cost goal formula:

% change in per capita GNP in constant dollars

2007	2.0
2008	(1.2)
2009	(4.7)
2010	2.9
4 yr. average	(0.3)

Using the latest population and economic statistics available, the cost goal for the period under review is estimated to be 1.0%, as shown below:

Inflation = 0.9

Real Economic Growth = (0.3)

$$\frac{[(100 + 0.9) \times (100 + (0.3)]}{100} - 100 = 0.6\%$$

Section 517 of the Act requires BCBSM to transmit an annual report to OFIR, which includes data necessary to determine the compliance or noncompliance with the cost and other statutory goals. The report must be in accordance with forms and instructions prescribed by the Commissioner and must include information as necessary to evaluate the considerations of Section 509(4).

As stated in Section 504(2)(e) of the Act, the "'[R]ate of change in the total corporation payment per member to each provider class means the arithmetic average of the percentage changes in the corporation payment per member for that provider class over the 2 years immediately preceding the commissioner's determination." The cost and membership data for the end stage renal disease provider class plan for the calendar years 2009 and 2010, as filed with OFIR by BCBSM, are presented below. Cost data reflect claims incurred in the calendar year and paid through February 28th of the following year.

Total Utilization and Payment Experience

BCBSM End Stage Renal Disease Figures	2008	2009	2010	Average Yearly Rate of Change
Total Payments	$5,696,179	$6,430,466	$4,219,161	
Total Members	156,325	147,626	118,497	
Cost Performance				
Payments/1000 Members	$36.4381	$43.5592	$35.6056	**0.6%**
Rate of Change (%)		19.5%	(18.3)%	**0.6%**

The two-year arithmetic average increase for the end stage renal disease provider class plan equals 0.6%. BCBSM states overall payments per 1000 members increased an average of 0.6% as a result of a 7.5% decrease in the average payment per claim partially offset by an 11.6% increase in the average number of claims per 1000 members.

BCBSM states that membership in its traditional product declined significantly since the implementation of the end stage renal disease PPO product in 2006. The decline in membership contributed to the highly fluctuating cost and use trends. Average payment per member remained constant in the current experience period; however, the average number of claims increased 11.6%, indicating that more members with end stage renal disease were utilizing these benefits.

ESRD Trends by Type of Service 2008-2010

Types of Service	Two Year Average Rate of Change			Three Year Payout	% of Total Payout
	Payments/ 1000 members	Cases/ 1000 members	Payment/ Visit		
Hemodialysis - Outpatient	4.6%	14.5%	(5.0)%	$13,813,911	84.5%
Laboratory/Pathology/EEG/Isotopes/Scans	114.5%	64.2%	10.8%	$128,096	0.8%
Hemodialysis - Home Service	(16.9)%	2.4%	(21.8)%	$2,403,799	14.7%
Total	0.6%	11.6%	(7.5)%	$16,345,806	100.0%

As illustrated above, major payout categories by type of service included hemodialysis – both outpatient and home services and laboratory/pathology/EEG/isotopes/scans. Outpatient hemodialysis experienced a 4.6% increase in payments per 1,000 members essentially due to a 14.5% increase in cases per member. Home service hemodialysis experienced a 16.9% decrease in payments per member mainly due to a 21.8% decrease in the average payment per case. Overall, all hemodialysis services accounted for 99.2% of the total payments even though laboratory/pathology/EEG/isotopes/scans had the most significant fluctuations in cost and use.

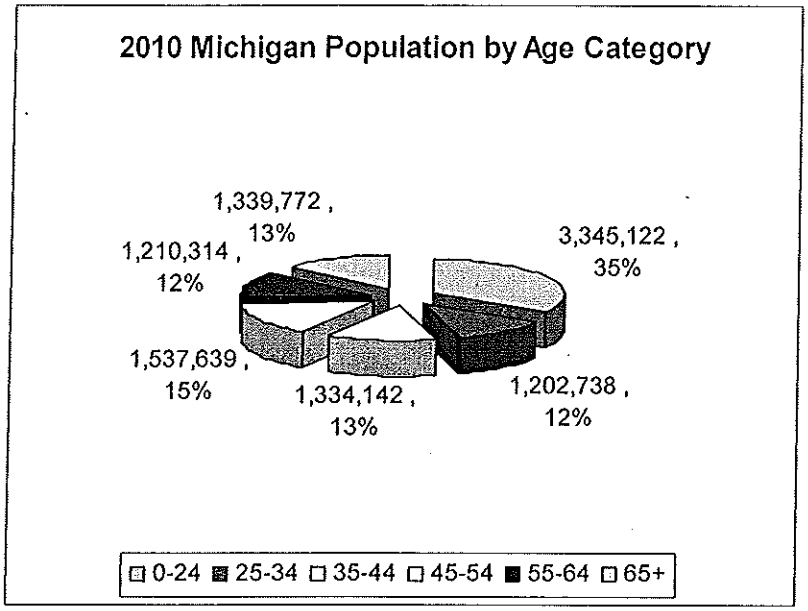
Cost and utilization data by region is detailed below. End stage renal disease trends by region show region one (southeastern Michigan) having the largest percent of total payout at 71.9%. This is to be expected given BCBSM information indicates region one clearly has the largest share of end stage renal disease members. BCBSM states that the largest percentage of members by age band shows services being provided to those aged 55-64 as being the largest contributor to the total payout.

ESRD Trends by Region – 2008-2010

Region	Two Year Average Rate of Change			Three Year Payout	% of Total Payout
	Payments/ 1000 members	Claims/ 1000 members	Payment/ Claim		
1	(8.3)%	1.8%	(11.8)%	$11,758,156	71.9%
2	0.0%	0.0%	0.0%	$279,108	1.7%
3	185.9%	419.8%	(6.4)%	$898,848	5.5%
4	4.7%	15.2%	(5.8)%	$1,024,787	6.3%
5	24.7%	(4.3)%	48.0%	$1,314,858	8.0%
6	18.1%	23.2%	57.3%	$469,393	2.9%
7	78.8%	60.5%	1.7%	$271,680	1.7%
8	(24.9)%	(32.4)%	1.5%	$328,975	2.0%
9	0.0%	0.0%	0.0%	$0	0.0%
Total	0.6%	11.6%	(7.5)%	$16,345,805	100.0%

Cost controls used during the two year period under review included monitoring Medicare eligible members to ensure they are enrolled in Medicare when the coordination period ended. Additionally, the implementation of the all-inclusive rates in late 2006 appears to have assisted stabilizing the costs since all facilities are now reimbursed the same rates.

The characteristics of a population can significantly affect that population's consumption of health care resources. BCBSM states that in 2010, membership for the end stage renal disease provider class declined 19.7%, or by approximately 29,000 members. The proportion of members utilizing end stage renal disease benefits also decreased in 2010. Members obtaining these services decreased by 55 patients or approximately 31.4%. The distribution of Michigan's 2010 population by age group is shown below:



Total national health care spending in 2010 was projected to rise 5.1% reaching $2.6 trillion dollars. Total health care spending represented 17.5% of the gross domestic product. BCBSM states that the expected acceleration in growth over the coming decade is expected to be the result of the implementation of the Patient Protection and Affordable Care Act as well as increases in subsidized coverage provided through the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Individuals with end stage renal disease who are on dialysis qualify for Medicare coverage the first day of the fourth month of dialysis treatment, regardless of age. For the first 30 months of treatment, the individual's employer-sponsored group health insurance is the primary payer for end stage renal disease services and Medicare is the secondary payer. After 30 months, Medicare is the primary payer for all services covered by Medicare, and the individual's group insurance becomes secondary payer. As a result of this policy, primary liability for medical care for end stage renal disease patients under age 65 is shifted to Medicare, thereby limiting liability of private insurers.

According to the Centers for Disease Control, by 2020, nearly 150,000 persons in the United States are projected to begin therapy for end stage renal disease, largely due to the aging of the population and the increasing prevalence of diabetes. It is predicted that by then nearly 800,000 people will be living on chronic dialysis or with a kidney transplant, with the national costs associated with end stage renal disease projected to reach approximately $54 billion.

There is a definite shift in the health care industry on both state and federal levels toward disease management programs as an attempt to control spiraling costs. Disease management aims at empowering participants to better manage and improve their own health, which in turn should help control costs of health care services. BCBSM states it

has broadened its scope of medical care management design. BCBSM no longer directs all of its attention to provider costs and provider utilization but instead has developed member-focused health management programs.

As noted in the quality of care section of this determination report, BCBSM has developed and made available a number of online coaching programs and online tools to help members address their key health challenges and take charge of their health. These programs, over time, will hopefully encourage members to live more healthy lifestyles and in return, lessen health care costs associated with all BCBSM provider classes, including the end stage renal disease provider class.

Findings and Conclusions - Cost

Based on the cost information analyzed during this review, it is determined that BCBSM met the cost goal stated in the Act for the end stage renal disease provider class during the two year period under review. This decision is based on the fact that the rate of change in the total corporation payment per member for the end stage renal disease provider class has been calculated to be 0.6% over the two years being reviewed and therefore met the compound rate of inflation and real economic growth of 0.6%.

BCBSM is encouraged to continue its efforts to find new, innovative programs that instill responsible cost controls so that all the goals and objectives of the corporation will continue to be achieved.

Determination Summary

In summary, BCBSM met all three statutory goals for the end stage renal disease provider class for the two-year period under review.

ATTACHMENT A